

**Additional Imputations of Employer Information for the Medical Expenditure  
Panel Survey  
Insurance Component Since 1996**

## **Background**

This report is the second report containing information on imputation of variables for the Medical Expenditure Panel Survey (MEPS) Insurance Component (IC). The MEPS-IC is a survey of employers, both private industry and public, that collects information on employer sponsored health insurance. The survey is sponsored by the Agency for Healthcare Research and Quality and conducted by the U.S. Bureau of the Census. It is designed to collect information on employment related health insurance, such as, premiums and types of plans offered. Information that describes characteristics of the employer is also collected. This data is used to classify employers for calculations of averages and totals and to serve as independent variables for economic modeling.

The sample design of the IC is described in Sommers, 1999. Imputation of missing data for 1996 is described in Sommers, 2000a. These documents reflect the survey as of the 1996 survey year. Since that time, sample from unions and insurers of respondents to the MEPS, Household Component (HC) have been dropped from the sample due to the low response rates. The sample of self employed individuals with no employees (SENE's) has also been dropped from the due to a combination of factors. The major reasons were low response rates and the fact that many self employed did not have insurance as self employed individuals, instead they obtained insurance through another employer or through their spouse's employment. Because the employers providing the insurance in these cases are covered through the main sample of employers, this further limited the number of sample persons with usable data. Combined with the low response rates, this caused the sample of SENE's to be of marginal value and it was dropped.

Since that first survey for the year, 1996, the list of variables imputed with the data have been expanded, significantly. Some of these are variables that were not originally collected, however, most are additions to the list that were collected for the 1996 survey year but not imputed. A copy of the standard 1999 IC data collection forms for establishments and plans are included as Appendixes A and B at the end of this document.

Because the imputations being described are an expansion of the previous list, and the basic technical methods are very similar, this paper will not give the level of detail of Sommers, 2000a.

This paper also assumes that the previous imputations described have been completed before the imputations described here take place. Due to these reasons, for the reader to have the clearest picture of the process, they are advised to be familiar with the previous work described in Sommers, 2000a.

## **General Technical Methods**

The original imputation methods report described the process for 7 groups of variables. Variables were grouped based on natural relationships. For instance, questions relating to whether an employer offered health insurance to retirees and whether they offered

insurance to retirees below age 65, above or both were done together. Likewise, the variables were ordered to maintain consistency. For instance, type of plan providers was imputed before premiums because premiums are influenced by type of plan providers (Sommers, 2000a).

The basic methods used to produce the additional new imputed results were similar to those used in developing the processes for the first seven sets of imputation. They are grouped and continue in order with later groups built using previous imputations if required. The new groups are numbered from 8 to 17. As before each group generally goes through 3 phases to produce imputed results:

- Data preparation - Data editing is completed and data is normalized, for example, all premium values are annualized.
- Donors are selected for each recipient needing a value. Generally this is done using a hot deck method which is similar for all groups. Specifics behind the hot-deck process can be found in Kalton and Kasprzyk (1986) and are based upon the premise that the expected values of two items is the same if both items agree on a set of important predictive characteristics. The method used to implement this technique was developed by Stiller and Dazell (1997). It depends on sorting the donors and recipients. As part of the process class and sort variables are developed and ordered. A donor and recipient must have the same class variables. If donors and recipients disagreed on any class variable then their expected difference in values have been determined to be too large. They can differ on the sort variables, which have less effect on expected values than class variables. Efforts are made to match on sort variables also, but these are ordered so that if not all variables are matched the least important are dropped first in the matching process. (A more extensive description of this process is given in Sommers, 2000a.)
- Final required values are produced. Many times there is a direct substitution of one or more donor values into the recipient's slots for the same variables. However, some of the recipient values are determined by using ratios or other values derived from the donor and applying them to a current recipient value. This is done to maintain consistency among the recipient results. For instance, to obtain the number of employees eligible for health insurance, the donor ratio of eligible to total employees is applied to the number of employees of the recipient. This maintains data relationships. If a direct substitution of the donor's eligible employees were used, either the process would need to be limited to donors with very similar values of total employees to the value of the recipient. Otherwise, the recipient values would likely have an expected value that was too high or too low dependent upon the relationship of the employment of the recipient to the average employment of the set of donors.

## Process for Each Group of Variables

In the next sections of the report, we proceed through each of the new groups of variables that were imputed for the MEPS - IC. For each group, we give the list of variables to be imputed with reference to their questionnaire name (establishment or plan) and question number (Copies of the standard establishment and plan questionnaires are given in Appendices A and B.). We also describe sort variables used in the selection of all donors for the individual variables within the group, describe class variables used for imputation for all individual variables within the group and describe the step by step process used to create values for each type of recipient from the donor information. Sort and class variables are given for imputation of private sector data. Changes made for imputation of government data are given in the last section of this report. Precise definitions of required class and sort variables are given in Appendix C.

We assume that all logical edits have been performed before the imputation takes places. Thus, for instance, if a respondent gave a total number of part time employees in question D1b as zero and did not fill in how many were eligible or enrolled, these values would automatically be set to zero. Because of this assumption we do not discuss logical edits in process descriptions unless this information adds to the discussion of the process.

Throughout the process, we assume a standard definition of a responding establishment and responding plan. An establishment was considered a respondent if it answered that it did or did not provide insurance for its employees and if the establishment did provide insurance for some of its employees, the establishment also responded at the plan level for at least one of its plans. Responding plans are defined as those that had information provided for at least one of the following items on the plan questionnaire (Appendix B) for the specific plan:

- Type of providers, question 2
- Gatekeeper required, question 3
- Purchased or self insured, question 4
- Plan active enrollment, question 7a
- Premium levels and contributions, questions 8 and 9.

In the following sections, we describe the imputations of variables in the new groups 8 through 17. As was done in the previous methods report (Sommers, 2000a), we give (1) the variables imputed in the groups, (2) the sort variables, in order of importance from most to least important, and (3) the class variables. Along with these lists, we give the processes used to convert data from the donor to create the recipient values.

## Eighth Group of Variables

Plan questionnaire (Pq) 6c  
Establishment questionnaire (Eq) E1

Annual plan cost for self insured plans.  
Total annual cost of coverage for all  
hospitalization/physician plans at the  
location.

### Sort Variables

None, hot deck process not used.

### Class Variables

None

### Process

To impute these values does not require the selection of any other donors. At this time all enrollments and premiums for each plan have been imputed in earlier imputation groups. Using the assumption that the plan premium and enrollments are the same for the entire year at the establishment, then the total annual cost for a plan is the number of single enrollees multiplied by the annual single premium plus the number of married enrollees multiplied by the annual married premium. Using this method directly gives an estimate of total annual plan cost for a self insured plan. The weighted sum of these estimates by plan for the set of plans collected for the establishment gives an estimate of the total annual cost at the location for hospitalization/physician plans. The weight used is the conditional plan weight within the establishment given the establishment is in the survey.

### **Ninth Group of Variables**

Eq E8a	Retirees in the firm covered by insurance.
Eq E8b	Retirees in the firm with single coverage.
Eq E9a	Retiree single coverage premium.
Eq E9b	Retiree single coverage employer contribution.
Eq E10a	Retiree family coverage premium.
Eq E10b	Retiree family coverage employer contribution.

(Note these questions do not apply to the establishment in the sample. They apply to the firm which controls the establishment. This is done because retiree data are not available at the establishment level and actually cannot always be related to a specific operating establishment. For instance, retirees within a firm that worked at a closed factory cannot be associated with a particular operating establishment. Thus, retiree questions are for the firm and require special estimation processes to be used in making estimates. For more information, see Sommers, 2000b.)

### Sort Variables

A different donor is selected for each recipient. A different set of sort variables is used for the hot deck for each variable imputed. This reflects the differing sets of predictors for each value. The variables listed have been placed in the same group because they are all questions concerning retiree coverage and imputation of some of these variables requires use of one of the previously imputed variables.

For retirees covered by insurance and retirees with single coverage, the sort variables are (1) whether the establishment offers health insurance to retirees under 65, (2) whether the firm offers health insurance to retirees over 65, (3) the industry division group, (4) the industry division, (5) Firm Age Group 2, and (6) Firm Size Class 2. (See Appendix C for variable definitions.)

For retiree single coverage premium the sort variables are (1) industry division group, (2) industry division, (3) Firm Size Class 2, (4) Firm Size Class 1, (5) Census division, (6) State, and (7) the size of the retiree family coverage premium.

For retiree single coverage employer contribution the sort variables are (1) industry division group, (2) industry division, (3) Firm Size Class 2, (4) Firm Size Class 1, (5) Census division, and (6) State.

For retiree married coverage premium the sort variables are (1) industry division group, (2) industry division, (3) Firm Size Class 2, (4) Firm Size Class 1, (5) Census division, (6) State, and (7) the size of the retiree single coverage premium.

For retiree married coverage employer contribution the sort variables are (1) industry division group, (2) industry division, (3) Firm Size Class 2, (4) Firm Size Class 1, (5) Census division, and (6) State.

### Class Variables

The class variables for all the hot deck imputations in this group are Firm Size Class 3 and whether the establishment offered health insurance to retirees.

### Process

The values of the retiree single coverage and retiree married coverage premiums are taken directly from the donor establishment. The other four variables are obtained by multiplying a ratio calculated from the donor times a value taken from the recipient. The total number of retirees for the firm is the number of employees for the firm of the recipient multiplied by ratio of the number of retirees from the donor establishment's firm over the total employment of the donor establishment's firm.

The total single enrollees is the total enrollment for the recipient multiplied by ratio of the total single enrollment for the donor's firm over the total enrollment for the donor's firm.

Each of the two contributions is calculated by multiplying the corresponding (family or single) premium for the recipient by the ratio of the donor plan's corresponding employer contribution over the donor plan's corresponding premium.

## **Tenth Group of Variables**

Eq E2a            Optional coverages offered.  
Eq E2b            Total cost of optional coverage.

### Sort Variables

The two variables are imputed in sequence, but the second value, does not use a hot deck routine and no sort values are used. For the first, variable, 'optional coverages offered', the file is sorted by industry division and Firm Size Class 1.

### Class Variables

The variable Firm Size Class 2 is used as a class variable for imputation of the first variable.

### Process

The first question if not answered is imputed directly from a donor who provided a response. A donor is an establishment that either checked that they did not offer any optional coverage or checked one or more of the optional coverages listed. A recipient is an establishment that either checked no box or checked that they did not offer coverage and then checked a coverage that was offered.

The total cost of optional coverage for an establishment for those establishments which offered this coverage, whether actual or imputed, which did not report a cost had their costs imputed by applying a factor to their total number of employees enrolled in health insurance.

The factors are derived from the costs of those establishments which reported both the coverages offered and their total costs. Each establishment could offer from 1 to 4 coverages. The reporting establishments are grouped by whether they offer 1, 2, 3 or 4 optional coverages. The weighted sum of the reported optional coverage costs for each group is calculated and divided by the weighted total of their enrolled to obtain a ratio of cost per enrollee for those establishments offering that number of optional coverages.

For each recipient, its total costs are determined by multiplying the establishment enrollment by the appropriate factor for the establishment based upon the number of coverages offered by the establishment. i.e., if the establishment offers two optional coverages its total cost is its enrollment times the average reported cost per enrollee for establishments which reported offering two optional coverages.

## **Eleventh Group of Variables**

Pq 8c                      How many former employees are enrolled in plan?

### Sort Variables

None, hot deck process not used.

### Class Variables

Firm Size Class 2 and industry division group

### Process

For each cell determined by the two class variables, the weighted sum for reported plans of the number of former employees enrolled was divided by the weighted sum of active enrollees for the reported plans within the same cell. To impute the number of former employees enrolled for a recipient plan, that plan's total enrollment was multiplied by the ratio calculated from reporting donor plans in the same cell.

### **Twelfth Group of Variables**

Pq 13a	Did plan have a deductible?
Pq 13b	What was annual individual deductible?
Pq 14a	Did the plan require a specific number of individual deductibles be met before the family deductible is met?
Pq 14b	How many family members were required to meet the individual deductible?
Pq 14c	What was the total annual family deductible?
Pq 15a	Was hospital care covered?
Pq 15b	How much and/or what percentage was paid by enrollee for hospital care?
Pq 15c	Is physician care covered?
Pq 15d	How much or what percentage was paid by enrollee for physician care?

### Sort Variables

The imputation is done in sequence with four hot deck steps. The variables are imputed in the following order:

- Did the plan have a deductible?
- Was the family deductible a multiple of the single deductible?
- Did the plan have hospital coverage and did the plan have physician coverage?
- The remaining variables in the list.

For the first two hot deck runs, the files are sorted by (1) Firm Size Class 2, (2) state, and (3) size of the single premium. For the remaining two runs the files are sorted by (1) Firm Size Class 2, (2) type of provider, (3) State, and (3) size of plan single premium.

### Class Variables

The class variable for whether the plan had a deductible is the type of provider. There are no class variables for the second and third hot deck runs. The class variables for the fourth hot deck run are did the plan have a deductible and was the family deductible a multiple of the single deductible.

### Process

The variables are related because each set relies on information from the previous imputation either to determine if there needs to be an imputation at that point or to determine a class variable for the next imputation. For instance, we must know if there is a deductible from the first imputation in order to know if there needs to be an imputation for the family deductible. The variables from the first three imputations are needed to determine the structure of the imputation results for the large number of variables imputed in the fourth hot deck. The process approach is given below.

Due to the close interaction of the variables in this group, an important first step is taken using a large number of logical edits. For instance, if a plan has deductibles reported, then it is assumed that the plan had deductibles. If copays are given for physician visits, then it is assumed that physician care was covered. Once these edits have been carried out, then the imputation steps are done in a sequence that builds the information in a logical correlated manner.

The first step is to determine if there was a deductible. A recipient in this group would not have information about whether the plan had a deductible and likely would also not have any information about most of the other variables in this overall group. They would certainly not have any information on the type of family deductible imputed in the second hot deck process nor the levels of the various deductibles in the fourth hot deck group above.

In this first step, a donor is a plan that had reported whether there was a plan deductible. The value of the donor is directly imputed into the recipient value to determine if the recipient had a deductible.

The donors for the second set are those plans which have a deductible and information on the structure of the family deductible. Recipients lack information on the nature of the family deductible but were known to have had a deductible. As with the first hot deck step, the donor value is directly imputed into the recipient value.

The third hot deck determines if plans offered physician coverage and/or hospitalization coverage. These two values are determined at this stage of the imputation process

because most of the remaining variables in the imputation group are related to one of these types of care. For instance, hospital copays must be determined, but before one can determine if there is a hospital copay, one must know if there is hospital coverage. If there is no coverage there is no copay.

For this third hot deck run, the donor plans are all those plans who answered both the questions about type of coverage offered. Recipient plans are those plans which failed to report if the plan covered either hospital coverage, physician coverage or both. The donor value is directly imputed into the recipient value if the recipient needs such a value. For instance, if the recipient plan was reported to have hospitalization coverage, but failed to report about physician coverage, then only the donor's value about physician coverage would be used.

For the fourth hot deck, donors are plans which have all the information for all the items in the group that would be required (For instance, if the plan had no deductible its deductibles could be blank.) and that offered family coverage, physician coverage and hospitalization coverage. Recipients are plans for which it is known whether they have a deductible, which types of coverage are included, and whether a family deductible is a multiple of the single deductible. However, necessary details in these areas are not known. For instance, if the plan had a deductible, not all required deductible values are known. If the plan had hospitalization coverage, then it is not known what the copays/percentage paid by the enrollee were.

There is only one donor per recipient. Donors have information for all the possible fields to be imputed. This means a donor is sometimes required to have more than the minimum information required to choose a donor or to provide values for the recipient. For instance, all donors have values for physician copays, but the recipient may not require a physician copay because the plan does not have physician coverage or the recipient plan has had this copay reported. Likewise, the recipient plan may not offer family coverage and thus not require a family deductible but the donor plan, if it has a deductible, would have family deductibles in case they were needed for the imputation. This completeness and use of the two variables, whether the plan has a deductible and the type of married deductible, assure that the donor plan will have all the information required for any recipient plan in the class. This donor specification was used because (1) almost all reporting plans had the two types of coverage and married coverage and (2) if any information was given complete information was given. Thus (1) very few donors are removed from the imputation by the restriction leaving a large supply of donors, (2) it allows the imputation to be carried out using a simpler process with fewer steps by selecting a single donor for all these variables and then using only the needed information, (3) it helps maintain correlation and consistency of data by using the same donor and (4) matches of donor and recipient are still made using the most important prediction variables.

What information is used from the donor and how it is used to provide information for the recipient depends upon the pattern of reported information the recipient plan has. The process is such that a determination is made as to which sections of the recipient plan are

missing information, then the process considers each section and the pattern of missing information within that section.

The process handles the remaining items in three parts, all of the deductibles are processed together as a group, the hospital copay/percent paid and the physician copay/percent paid are each handled a separate groups independent of the other and the deductibles.

The process for the deductibles requires that donor relationships be maintained when imputing values to the recipient using donor ratios of family to single deductibles. How each item is calculated depends upon what values have been reported for the donor and recipient. One must also remember that at this point in the process one knows whether the family deductible is a value or a multiple of the single deductible for both the donor and the recipient. Since these variables are class variables in this imputation, the donor and recipient share this characteristic. One also knows whether both the donor and recipient have a deductible. Again, this is because this is a class variable in the process. One also has if necessary imputed what type of coverages the recipient provides so one knows if one requires a married deductible or hospitalization deductible or physician deductible. On the other hand the donor always has each of these three types of coverage and thus can provide for all three types of coverage within its class even if the recipient does not need all three.

Data from donors are used in a way to both retain relationships of the data within the donor and at the same time retain any recipient information available. What is done depends upon the case and what the donor and recipient deductible information is. Some of the key cases, are as follows:

- If the recipient has no deductible, then the deductibles are left empty.
- If the recipient has a deductible and is missing all deductible values, the donor values are simply imputed to the recipient.
- If the recipient requires a family deductible but has a single deductible one gets the family deductible by multiplying the reported recipient single deductible by the ratio of family to total single deductible of the donor. If the recipient has a family but no single deductible, the process is reversed and the recipient family deductible is divided by the donor ratio to obtain the single deductible.
- To preserve whether there is a single individual deductible or separate deductibles for hospital and physician care, if a single deductible is calculated for the recipient using a donor ratio of total single deductible, and the donor has separate deductibles then the total recipient value is prorated into separate deductibles using donor values. For instance, if the recipient reported no single deductible but a family deductible of 200, and the donor had a family deductible of 300 and two separate individual deductions of 75, then the total single deductible for the recipient would be  $100 = 200 * (75 + 75) / 300$ . The 100 would then be prorated to

50 and 50 using the portions 75 and 75 from the donor to allocate the 100 between the two individual deductibles.

- For cases where the donor and recipient both have family deductibles which are multiples of their single deductions, if the recipient does not have a single deductible, family deductible nor has the number of single deductibles required for the family deductible, then all donor values are imputed to the recipient. However, if the recipient has no single deductible but has a number of times the single deductible is required for family coverage, then only the recipient single deductible is taken from the donor. As above, if the single deductible of the donor is broken into two separate deductibles, then this pattern would be imputed to the recipient.
- Only required values are imputed. For instance, if a recipient plan has no family coverage, then no family deductibles are taken from the donor. Thus if a recipient was missing all values of deductibles but from earlier work, one knew that no family coverage was offered, then the family deductible from the donor would not be used for this recipient.

The imputation of copays/percent paid are basically direct transfer of values from the donor. Donors for the hospitalization copays/percents had a reported value for either the copay or the percent. It was assumed that if one were reported and the other value missing that the other value was zero. It was also assumed that if a plan had reported an amount paid that it was per stay unless the donor reported otherwise. Recipients for hospitalization copays/percents had both the hospital values missing, but offered hospital coverage. The recipient takes from the donor plan the values of all three variables in the set.

For physician copays/percents, the same assumptions and edits were made as for hospitalization values. Thus, for physician copay/percents, a recipient plan was a plan with physician coverage and no copay or percentage reported, a donor plan had at least one of the two values reported.. As with hospitalization, the recipient values were taken directly from the donor.

### **Thirteenth Group of Variables**

Pq 17a                      Did the plan have a maximum out-of-pocket for an individual and if so how much?

#### Sort Variables

State

#### Class Variables

Type of provider, Pq 2

Process

The two variables in question Pq 17a are related. Only one of the two should be answered. Donors are those plans with valid responses to the question, that is, either they had no maximum or there was a maximum given. Recipients are those plans that had neither of the two questions answered or both.

Imputation from donor to recipient is by direct substitution of donor to recipient value.

**Fourteenth Group of Variable**

Pq 17b	Did the plan have a maximum out-of-pocket for a family and if so how much?
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Sort Variables

State

Class Variables

Type of provider, Pq 2

Process

The two variables are related. Only one of the two should be answered. Donors are those plans with valid responses to the question, that is, either they had no maximum or there was a maximum given. Recipients are those plans that had neither of the two questions or both.

Imputation from donor to recipient is by direct substitution of donor to recipient value.

**Fifteenth Group of Variables**

Pq 21	Does plan offer routine outpatient prescription coverage, ... dental care, ...orthodontic care (Only these three types of coverage are imputed)?
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Sort Variables

State

### Class Variables

Type of provider, Pg 2

### Process

Donors are those plans which have answered either yes or no to all three of these items. Recipients are those plans without a yes or no answer to all three items. To impute, there is a direct transfer of the donor value for any or all of the three items which are not reported on the recipient plans.

### **Sixteenth Group of Variables**

Eq E3a                      Did the establishment require a waiting period before a new employee could be covered by health insurance?

Eq E3b                      If a waiting period was required, for 1999, how long was the typical waiting period?

### Sort Variables

Firm age group, industry division group, SIC2, Firm Size Class 1, State, and establishment size class.

### Class Variables

None

### Process

The process requires two hot deck imputations. Only establishments which offer health insurance are considered. The donor set for the first hot deck is all establishments which reported whether or not they had a waiting period for health insurance. The recipient set is all establishments which failed to answer whether they required a waiting period for health insurance. Imputation of the recipient value is by direct substitution of the donor value.

The donor set for the second imputation is the set of all establishments which require a waiting period for health insurance for their employees and reported the length of that period. Recipients are those establishments which either reported or had imputed that they had a waiting period for their employees before health insurance coverage began, but failed to report the length of that waiting period. The recipient value of the waiting period length is set equal to the value of the donor's waiting period.

### **Seventeenth Group of Variables**

Pq 18a	Could the plan have refused to cover persons with certain pre-existing conditions?
Pq 18b	Did this happen in 1999?
Pq 19	Did the plan have a policy requiring a waiting period before covering a pre-existing condition?

#### Sort Variables

Census division, state, Firm Size Class 2, and establishment employment

#### Class Variables

Type of provider, Pq 3

#### Process

The process is completed in three steps. First, all plans which were missing an answer about whether a person could have been refused coverage for a pre-existing condition are recipients. Donors have a reported value for the question. Imputation of a value is direct placement of the donor value into the recipient value.

Plans which could deny coverage due to pre-existing conditions but did not indicate if this had happened were recipients for the second value. Donor plans reported if someone had been denied coverage for a condition. Again imputation was to directly copy the donor value to the recipient.

The third imputation was similar to the first two. Donor plans had a reported value for the question, recipient plans did not. Imputation was by direct transfer of the donor value to the recipient.

#### **Government Imputation Process**

The imputation process for sampled governments imputes the same data items as the private sector establishments. The process is similar to that of the private sector. The only differences are sort and class variables used. For government case imputation, the same sort variables are used for all data Groups. These are, in sort order, region, state and government employment size. For government cases there are no class variables that describe the government. Class variables used are only the specialized variables for plans which apply to that particular imputation group. Thus, for instance, for Group 11, for the private sector, Firm Size Class 2 and industry division class are class variables. For government case imputation, both would be dropped. For the various imputations in Group 12, the variables type of provider, did the plan have a deductible, and was the family deductible a multiple of the single deductible are class variables and are kept for government imputation. The size and industry division variables in Group 11 are dropped because they would describe the government and this type variable is not used.

For the Group 12 imputation the three variables are kept because they are characteristics of the plan and these variables were used.

## References

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## **Appendix A. Establishment Questionnaire**

1999 Medical Expenditure Panel Survey  
Insurance Component

# HEALTH INSURANCE COST STUDY

## Establishment Questionnaire

*(Please correct any errors in name, address, and ZIP  
Code. Enter number and street if not shown.)*

U.S. DEPARTMENT OF COMMERCE  
Economics and Statistics Administration  
U.S. CENSUS BUREAU  
ACTING AS COLLECTING AGENT FOR  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

RETURN TO

**U.S. Census Bureau  
1201 East 10th Street  
Jeffersonville, IN 47132-0001**

**PLEASE RETURN ENTIRE PACKAGE WITHIN**

***PLEASE DO NOT REMOVE COVER***

## INSTRUCTIONS

- 1.** Please report for the establishment identified on the cover sheet, unless otherwise specified.
- 2.** Please report data for 1999.
- 3.** Estimates are acceptable.
- 4.** Refer to the Definition Sheet included with this package for explanation of unfamiliar terms.
- 5.** If you have any questions or need assistance in completing the questionnaire, please call

### Paperwork Reduction Act and Burden Statements

We expect that it will take 45 minutes, on average, per establishment, to complete the basic questionnaire. Establishments with more than one health plan will take an additional 10 minutes per plan, on average, up to the maximum of four plans to be reported. In addition, we estimate that it will take 15 minutes to review the instructions and locate the requested information. You may send any comments regarding this burden estimate or any other aspect of the collection of information, including suggestions for reducing burden, to the following address: Director, Center for Cost and Financing Studies, Paperwork Reduction Project 0935-0110, Agency for Healthcare Research and Quality, Executive Office Center, Suite 500, 2101 East Jefferson Street, Rockville, MD 20852-4908.

## Section A – NUMBER OF PLANS

*Please respond for the location identified on the cover sheet unless otherwise specified.*

*Respond for active employees only.*

- 1a. Did your organization make available or contribute to the cost of any health insurance plans for its employees in 1999?

For this survey, a health insurance plan is hospital and/or physician coverage made available to employees.

- 001 1 ☐ Yes – Continue with Question 1b  
2 ☐ No – **SKIP to Section B**

- b. How many different health insurance choices did your organization make available or contribute to for its employees during the 1999 plan year?

*Do not count single service plans (optional plans) such as dental or vision.*

Plans offered by the same insurance company which offer:

- Single and family plans providing the same level of benefits count as one plan.
- High and standard options count as two plans.
- An HMO and a conventional plan count as two plans.

003  **SKIP to Page 4, Section C**

## Section B – HEALTH INSURANCE NOT OFFERED

*Complete only if health insurance was NOT offered during 1999, otherwise; SKIP to Page 4, Section C.*

- 1a. Did your organization offer any health insurance as a benefit to its employees at this location between January 1, 1994 and December 31, 1998?

- 031 1 ☐ Yes – Continue with Question 1b  
2 ☐ No – **SKIP to Question 2**

- b. What was the last year your organization offered health insurance coverage to its employees at this location?

032  1  9  9  Last year offered

2. In 1999, did your organization pay the medical or hospital bills of its employees directly, other than for workers' compensation and/or injuries suffered on the job?

- 049 1 ☐ Yes  
2 ☐ No

- 3a. Instead of providing a health plan in 1999, did your organization provide a voucher or stipend to its employees which could be used to purchase health insurance?

- 045 1 ☐ Yes – Continue with Question 3b  
2 ☐ No – **SKIP to Page 4, Section C**

- b. Was this voucher or stipend to be used exclusively for health insurance or health care?

- 046 1 ☐ Yes  
2 ☐ No

- c. What was the average value PER EMPLOYEE of this voucher or stipend at this location?

047 \$    ,   . 0 0 Voucher value

- d. How frequently was this voucher or stipend paid?  
*Mark (X) only one.*

- 048 1 ☐ Weekly  
2 ☐ Every 2 weeks  
3 ☐ Monthly  
5 ☐ Quarterly  
4 ☐ Yearly

**Continue with Page 4, Section C**

## Section C – EMPLOYMENT CHARACTERISTICS

Estimates are acceptable for all employment, eligibility, and enrollment figures.  
**Include officers, owners, part-time, temporary and seasonal employees.**  
**Exclude leased or contract workers.**

1. What was the total number of employees your organization had at ALL locations for a typical pay period in 1999?

034

Employees at all locations

*Complete questions 2–7 for the location listed on the cover sheet.*

- 2a. How many employees were on your organization's payroll AT THIS LOCATION for a typical pay period in 1999?

200

All employees at this location

*If your organization did not offer health insurance in 1999, SKIP to Question 3a.*

- b. How many of these employees were eligible for at least one health plan through your organization?

201

Eligible employees

- c. How many of these employees were enrolled in any health plan through your organization?

202

Enrolled employees

- 3a. For the same typical pay period in 1999, how many of the employees reported in C2a worked part-time?

203

Part-time employees

*If your organization did not offer health insurance in 1999, SKIP to Question 4a.*

- b. How many of these part-time employees were eligible for at least one health plan through your organization?

204

Eligible part-time employees

- c. How many of these part-time employees were enrolled in any health plan through your organization?

205

Enrolled part-time employees

- 4a. For the same typical pay period in 1999, how many of the employees reported in C2a were temporary or seasonal employees?

206

Temporary or seasonal employees

*If your organization did not offer health insurance in 1999, SKIP to Question 5.*

- b. How many of these temporary or seasonal employees were eligible for at least one health plan through your organization?

207

Eligible temporary or seasonal employees

- c. How many of these temporary or seasonal employees were enrolled in any health plan through your organization?

208

Enrolled temporary or seasonal employees

5. Is the information you provided in questions 2, 3, and 4 above for the location listed on the cover sheet OR did you provide information for multiple locations?

550

- 1 ☐ Information for specified location  
 2 ☐ Information for multiple locations

## Section C – EMPLOYMENT CHARACTERISTICS – Continued

**Provide information for a typical pay period in 1999.**

Estimates are acceptable.

*The following workforce characteristics are used to group similar organizations together for analytical purposes.*

<p>6a. What percentage of the employees at this location were women?</p>	016	<input style="width: 50px; height: 20px;" type="text"/> %	Women employees
<p>b. What percentage of the employees at this location were 50 years old or older?</p>	017	<input style="width: 50px; height: 20px;" type="text"/> %	Employees 50 years old or older
<p>c. What percentage of the employees at this location were union members?</p>	018	<input style="width: 50px; height: 20px;" type="text"/> %	Union members
<p>d. For the employees at this location in 1999, approximately what percentage earned –</p> <p>Less than \$6.50 per hour? . . . . .</p> <p>Approximately \$13,000 a year or less</p> <p>Between \$6.50 and \$15.00 per hour? . . . . .</p> <p>Approximately \$13,000 to \$30,000 a year</p> <p>More than \$15.00 per hour? . . . . .</p> <p>Approximately \$30,000 a year or more</p>	022	<input style="width: 50px; height: 20px;" type="text"/> %	Earned less than \$6.50 per hour
	023	<input style="width: 50px; height: 20px;" type="text"/> %	Earned between \$6.50 and \$15.00 per hour
	024	<input style="width: 50px; height: 20px;" type="text"/> %	Earned more than \$15.00 per hour
<p>7. How many hours per week must an employee work to be considered full-time at this location?</p>	041	<input style="width: 50px; height: 20px;" type="text"/>	Hours

*Continue with Page 6, Section D*

- 1a. Which of the following categories best describes the operational status of the establishment at this location at the end of 1999?
- Mark (X) only one.*

Mark (X) only one.

**SKIP to**  
**Question 2a**

*Continue with*  
*Question 1b*

- b. During what month and year did this establishment's change in operational status occur?  
Enter two digit numeric responses  
Example: January 1999 –

Example: January 1999 - **01** **1999**

Example: January 1999 – **01** **1999**

Yr.

- 2a. Did your organization offer any of these fringe benefits to its employees at this location in 1999?
- See Definition Sheet included with this package for explanation of benefits.*
- Mark (X) all that apply.*

*See Definition Sheet included with this package for explanation of benefits.*

*Mark (X) all that apply.*

Mark (X) all that apply.

566

- b. If your organization offered a Flexible benefit plan (Cafeteria Plan), what was the average annual value of the plan, for a TYPICAL EMPLOYEE, at this location?

Flexible benefit plan value

3. Which one of these categories BEST describes your type of business ownership?  
*Mark (X) only one.*

Mark (X) only one.

- 1 ☐ S corporation
- 2 ☐ Corporation
- 3 ☐ Partnership
- 4 ☐ Sole proprietorship
- 5 ☐ Government (Federal, state, or local)
- 6 ☐ Joint venture or cooperative

4. Is this a not-for-profit business?

1 ☐ Yes

2 ☐ No

5. Which one of these categories BEST describes the principal business activity at this location?
- If more than one apply, mark the category which generates the most revenue.*
- Mark (X) only one.*

*If more than one apply, mark the category which generates the most revenue.*

*Mark (X) only one.*

Mark (X) only one.

- 1 ☐ Retail trade
- 2 ☐ Personal services (e.g., beauty shops, dry cleaners)
- 3 ☐ Business services (e.g., advertising, computer processing)
- 4 ☐ Other services (e.g., legal and health services)
- 5 ☐ Manufacturing
- 6 ☐ Wholesale trade
- 7 ☐ Finance, insurance, or real estate
- 8 ☐ Transportation, communication, electric, gas, or sanitary services
- 9 ☐ Construction
- 10 ☐ Agriculture or forestry
- 11 ☐ Mining

6. Approximately how many years has your company been in business?
- If your organization operates at more than one location, enter the number of years the parent company has been in business.*

*If your organization operates at more than one location, enter the number of years the parent company has been in business.*

Approximate number of years in business

**If your organization DID offer health insurance coverage to its employees in 1999, continue with Page 7, Section E. If your organization DID NOT offer health insurance coverage to its employees in 1999, SKIP to Page 8, Section F.**



8a. What was the total number of retirees covered by health insurance through your organization at all of its locations in 1999?	513	<input type="text"/>	Retirees covered by insurance
b. What percentage of these retirees were enrolled in single coverage?	554	<input type="text"/> %	Retirees enrolled in single coverage
9a. For a typical plan in 1999, how much did the EMPLOYER contribute toward the monthly plan premium for ONE TYPICAL retiree with single coverage?	515	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> 0 <input type="text"/> 0	Employer contribution
b. For this same plan, what was the total monthly premium for this typical retiree with SINGLE coverage?	514	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> 0 <input type="text"/> 0	Single coverage premium
10a. For a typical plan in 1999, how much did the EMPLOYER contribute toward the monthly plan premium for ONE TYPICAL retiree with family coverage?	556	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> 0 <input type="text"/> 0	Employer contribution
b. For this same plan, what was the total monthly premium for this typical retiree with FAMILY coverage? <i>For retirees, if premiums vary, report for a family of two.</i>	555	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> 0 <input type="text"/> 0	Family coverage premium

## Section F – PERSON COMPLETING THIS QUESTIONNAIRE

**\*\*\* PLEASE NOTE \*\*\***

***If your organization offered health insurance, please complete Section F and the attached MEPS-10(S), Plan Information Questionnaire for each plan offered.***

***If your organization DID NOT offer health insurance, please complete Section F and END the form.***

**\*\*\* PLEASE NOTE \*\*\***

***If your organization offered health insurance, please complete Section F and the attached MEPS-10(S), Plan Information Questionnaire for each plan offered.***

***If your organization DID NOT offer health insurance, please complete Section F and END the form.***

**\*\*\* PLEASE NOTE \*\*\***

***If your organization offered health insurance, please complete Section F and the attached MEPS-10(S), Plan Information Questionnaire for each plan offered.***

***If your organization DID NOT offer health insurance, please complete Section F and END the form.***

212 Name <i>(Please print)</i>				213 Title									
Signature						214 Date <i>(Month/Day/Year)</i>							
						M	M	D	D	Y	Y	Y	Y
215 Telephone number (      )		220 Extension	216 FAX number (      )			217 E-Mail address							

## **Appendix B. Plan Questionnaire**

U.S. DEPARTMENT OF COMMERCE  
Economics and Statistics Administration  
U.S. CENSUS BUREAU  
ACTING AS COLLECTING AGENT FOR  
U.S. DEPARTMENT OF  
HEALTH AND HUMAN SERVICES  
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Medical Expenditure Panel Survey  
Insurance Component

## HEALTH INSURANCE COST STUDY PLAN INFORMATION QUESTIONNAIRE

### INSTRUCTIONS

The MEPS-10(S), Plan Information Questionnaire, is to be completed for the health insurance plans offered AT THIS LOCATION in 1999. Please respond for the plans indicated in the question 1a box of each MEPS-10(S). If no plan names are preprinted, complete a separate MEPS-10(S) for the 4 largest plans your organization offered. You may use photocopies of this MEPS-10(S) form if sufficient copies were not included in this reporting package.

### GENERAL PLAN INFORMATION

		FOR CENSUS USE ONLY	
<p><i>If a plan name is preprinted in the question 1a answer box on the right, answer for the plan specified. Otherwise, complete this Plan Information Questionnaire for the plan with the largest (or next largest) enrollment of active employees.</i></p>		100	
1a.	<p>For 1999, what was the name of the health insurance plan with the largest (or next largest) enrollment of active employees?</p> <p>Examples: • Blue Cross Blue Shield, High Option • Option A • Aetna HMO</p>	1012	Name of plan
b.	<p>What was the name of the insurance company or carrier providing this plan?</p> <p>Examples: • Blue Cross Blue Shield • Alliance • Charter Health</p> <p><i>Enter your company name if self-insured.</i></p>	102	Name of insurance carrier
2.	<p>Which type of health care provider was available through this plan?</p> <p><b>Exclusive providers</b> – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit.</p> <p><b>Any providers</b> – Enrollees may go to providers of their choice on a fee-for-service basis. The plan does not have any associated providers.</p> <p><b>Mixture of preferred and any providers</b> – Enrollees may go to a set of "preferred" providers associated with the plan or providers of their choice. If they go to a non-preferred provider, they face higher costs.</p>	103	<p>1 <input type="checkbox"/> Exclusive providers (Examples: Most HMO, IPA, and EPO-type plans)</p> <p>2 <input type="checkbox"/> Any providers (Examples: Most conventional and indemnity plans)</p> <p>3 <input type="checkbox"/> Mixture of preferred and any providers (Examples: Most PPO and POS-type plans)</p>
3.	<p>Did this plan REQUIRE that the enrollee see a primary-care physician in order to be referred to a specialist?</p> <p><i>For plans with multiple options, answer for the "in-network" option.</i></p>	104	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
4.	<p>Was this plan purchased through a pooling arrangement with other employers such as a multi-employer welfare arrangement (MEWA)?</p>	112	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>

## GENERAL PLAN INFORMATION – Continued

5. Was this plan purchased from an insurance underwriter or was it self-insured?
- Purchased from an insurance underwriter** – (fully-insured)  
Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.
- Self-insured** – Your organization assumes the risk for the enrollees' medical expenses and may charge a premium to employees. This plan may be administered by a third party and may employ supplemental stop-loss insurance to limit unanticipated losses.

105

- 1 ☐ Purchased – ***SKIP to Page 3, question 7***
- 2 ☐ Self-insured – ***Continue with Question 6a***

*Complete questions 6a–g if this plan was self-insured.*

6a. Was this plan self-administered or did your organization employ an insurance company or other administrator?

- b. Did your organization purchase stop-loss coverage?

106

- 1 ☐ Self-administered
- 2 ☐ Insurance company or other administrator

107

1 ☐ Yes

2 ☐ No

- C. What was the ANNUAL COST of this plan for the 1999 plan year for this establishment?
- Include the following:*
- *Claims paid*
  - *Administrative costs*
  - *The cost of stop-loss coverage (if any)*

d. What percentage of the amount reported in 6c covered stop loss coverage and administrative costs?

108

\$															.	0	0
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Annual plan cost

- d. What percentage of the amount reported in 6c covered stop loss coverage and administrative costs?

560  % Percentage for stop loss coverage and administrative costs

- e. What was the monthly premium equivalent for ONE TYPICAL full-time employee with SINGLE coverage?
- Estimates are acceptable.
- Enter the COBRA amount when the premium equivalent is not available.*

f. What was the monthly premium equivalent for ONE TYPICAL full-time employee with FAMILY coverage?

Estimates are acceptable.

*Enter the COBRA amount when the premium equivalent is not available.*

*Family premiums should be calculated for a family of four if cost varies by family size.*

109

\$								.	0	0
----	--	--	--	--	--	--	--	---	---	---

Single coverage

- f. What was the monthly premium equivalent for ONE TYPICAL full-time employee with FAMILY coverage?
- Estimates are acceptable.
- Enter the COBRA amount when the premium equivalent is not available.*
- Family premiums should be calculated for a family of four if cost varies by family size.*

g. Are the amounts reported in 6e and 6f premium equivalents or COBRA amounts?  
*Mark (X) only one.*

110

\$					,			.	0	0
----	--	--	--	--	---	--	--	---	---	---

Family coverage

- g. Are the amounts reported in 6e and 6f premium equivalents or COBRA amounts?  
*Mark (X) only one.*

111

1 ☐ Premium equivalents

2 ☐ COBRA amounts

*Continue with Page 3, question 7.*



FAMILY COVERAGE PREMIUMS

*Report for typical situations and enrollees.  
If premium varies, report for an average employee.  
Report employer/employee contributions and total premium for the same period.  
Report for a family of four if cost varies by family size.*

10a. Was family coverage offered under this plan?

b. For this plan, how much did the employer contribute toward the plan premium of ONE TYPICAL full-time employee with family coverage?

C. How much did this typical employee with family coverage contribute toward his/her own premium?

d. What was the total premium for this typical employee with family coverage?

e. The amounts reported in questions 10b-d are based on which one of the following time periods?

*Mark (X) only one.*

## GENERAL PREMIUM INFORMATION

--	--

11a. Did the PREMIUMS charged by the insurance company or carrier vary by any of these characteristics?

*Mark (X) all that apply.*

b. Did the amount an EMPLOYEE CONTRIBUTED toward his/her own coverage vary by different employee categories?

Examples: Full-time, part-time, union status, wage or salary levels

12. Did the plan premium include life and/or disability insurance?  
*Mark (X) all that apply.*

13a. Did this plan have a deductible?  
Deductible – Predetermined amount which must be met by an individual before the plan will pay for covered services.  
Many HMOs do not have a deductible.

151

1 ☐ Yes – *Continue with question 13b*

2 ☐ No – ***SKIP to Page 6, question 15a***

b. What was the annual deductible an individual paid?

*Report deductibles for care received "in-network" from preferred providers, if applicable.*

*Enter physician care and hospital care amounts in appropriate boxes if separate deductibles apply.*

*If deductible is per overnight hospital stay, it is not an annual deductible and should be reported under 15b on Page 6.*

**146**

\$		,				.	0	0
----	--	---	--	--	--	---	---	---

Individual annual deductible

OR

Separate deductibles for:

**147**

\$		,				.	0	0
----	--	---	--	--	--	---	---	---

Physician care

**148**

\$		,				.	0	0
----	--	---	--	--	--	---	---	---

Hospital care

## FAMILY DEDUCTIBLES

14a. Did this plan require that a specific number of family members must meet their individual deductibles before the family deductible was met?

224 1 ☐ Yes – *Continue with question 14b*  
2 ☐ No – **SKIP to question 14c**  
3 ☐ Family coverage not offered – **SKIP to Page 6, question 15a**

b. How many family members were required to meet their individual deductibles before the family deductible was met?

*Report for typical situations and enrollees.*

150  Number of family members

C. What was the total annual deductible a family paid?  
*Report for a family of four.*

149 

\$			,				.	0	0
----	--	--	---	--	--	--	---	---	---

 Total annual family deductible



## PLAN CHARACTERISTICS

<p>18a. Could this plan have refused to cover persons with certain pre-existing medical or health conditions?</p>	<p>183 1 <input type="checkbox"/> Yes – <i>Continue with question 18b</i>  2 <input type="checkbox"/> No – <b>SKIP to question 19</b></p>																																																																																															
<p>b. Did this happen in 1999?</p>	<p>184 1 <input type="checkbox"/> Yes  2 <input type="checkbox"/> No</p>																																																																																															
<p>19. Did this plan have a policy requiring a waiting period before covering pre-existing conditions?</p>	<p>185 1 <input type="checkbox"/> Yes  2 <input type="checkbox"/> No</p>																																																																																															
<p>20. In what month did the plan year begin?  <i>Enter a two-digit numeric response.</i>  Example: January = 01; May = 05</p>	<p>123 <span style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; vertical-align: middle;"></span> <span style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; vertical-align: middle;"></span> Month</p>																																																																																															
<p>21. Which of the services listed were covered by this plan?</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 70%;"></th> <th style="width: 10%; text-align: center;">Yes (1)</th> <th style="width: 10%; text-align: center;">No (2)</th> <th style="width: 10%; text-align: center;">Don't know (3)</th> </tr> </thead> <tbody> <tr><td>164</td><td>Routine mammograms . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>165</td><td>Adult routine physical exams . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>166</td><td>Routine pap smears . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>167</td><td>Office visits for prenatal care . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>168</td><td>Adult immunizations . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>169</td><td>Child immunizations . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>170</td><td>Well-baby care, under 1 year . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>171</td><td>Well-child care, 1–4 years . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>173</td><td>Chiropractic care . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>174</td><td>Other non-physician providers (such as physical therapists, podiatrists, and midwives) . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>175</td><td>Outpatient prescriptions . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>176</td><td>Routine dental care . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>177</td><td>Orthodontic care . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>178</td><td>Skilled nursing facility (convalescent care) . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>179</td><td>Home health care . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>180</td><td>Inpatient mental illness . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>181</td><td>Outpatient mental illness . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>182</td><td>Alcohol/substance abuse treatment . . . . .</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>			Yes (1)	No (2)	Don't know (3)	164	Routine mammograms . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	165	Adult routine physical exams . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	166	Routine pap smears . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	167	Office visits for prenatal care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	168	Adult immunizations . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	169	Child immunizations . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	170	Well-baby care, under 1 year . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	171	Well-child care, 1–4 years . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	173	Chiropractic care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	174	Other non-physician providers (such as physical therapists, podiatrists, and midwives) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	175	Outpatient prescriptions . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	176	Routine dental care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	177	Orthodontic care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	178	Skilled nursing facility (convalescent care) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	179	Home health care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	180	Inpatient mental illness . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	181	Outpatient mental illness . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	182	Alcohol/substance abuse treatment . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Yes (1)	No (2)	Don't know (3)																																																																																												
164	Routine mammograms . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
165	Adult routine physical exams . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
166	Routine pap smears . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
167	Office visits for prenatal care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
168	Adult immunizations . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
169	Child immunizations . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
170	Well-baby care, under 1 year . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
171	Well-child care, 1–4 years . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
173	Chiropractic care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
174	Other non-physician providers (such as physical therapists, podiatrists, and midwives) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
175	Outpatient prescriptions . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
176	Routine dental care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
177	Orthodontic care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
178	Skilled nursing facility (convalescent care) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
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180	Inpatient mental illness . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
181	Outpatient mental illness . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
182	Alcohol/substance abuse treatment . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												

### \*\*\* PLEASE NOTE \*\*\*

***If your organization offered only one health insurance plan, please end the form.***

***If your organization offered more than one health insurance plan, please complete a General Plan Information Questionnaire for each plan that was offered, up to four plans.***

## **Appendix C. Definitions of Selected Variables**

### **Firm Size Class 1**

- 1 if enterprise employment = 0-5
- 2 if enterprise employment = 6-24
- 3 if enterprise employment = 25-99
- 4 if enterprise employment = 100-999
- 5 if enterprise employment = 1000 or more

### **Firm Size Class 2**

- 1 if enterprise employment = 0-249
- 2 if enterprise employment = 250 or more

### **Firm Size Class 3**

- 1 if enterprise employment = 0-4999
- 2 if enterprise employment = 5000 or more

### **Establishment Size Class**

- 1 if establishment employment = 0-10
- 2 if establishment employment = 11 or more

### **Industry Division**

- agriculture if two-digit SIC = 01-09
- construction if two-digit SIC = 15-17
- retail trade if two-digit SIC = 52-59
- mining if two-digit SIC = 10-14
- finance, insurance and real estate if two-digit SIC = 60-67
- wholesale trade if two-digit SIC = 50-51
- manufacturing if two-digit SIC = 20-39
- transportation, communication and utilities if two-digit SIC = 40-49
- services if two-digit SIC = 70-89

### **Industry Division Group**

- 1 if industry division = agriculture, construction or retail trade
- 2 if industry division = manufacturing, transportation, communication, utilities or services
- 3 if industry division = mining, finance, insurance, real estate or wholesale trade

### **SIC2**

The first two digits of the establishment's six digit Standard Industrial Classification (SIC) Number

### **Firm Age Group**

1 if age = 0-16

2 if age = 17 years or more

### **Firm Age Group 2**

1 if age = 0-4

2 if age = 5-9

3 if age = 10-14

4 if age = 15-19

5 if age = 20 years or more

### **Census Division**

New England if State = ME, NH, VT, MA, CT, RI

Mid- Atlantic if State = NY, NJ, PA

East North Central if State = OH, IN, IL, MI, WI

West North Central if State = MN, IA, MO, ND, SD, NE, KS

South Atlantic if State = DE, MD, DC, VA, WV, NC, SC, GA, FL

East South Central if State = KY, TN, AL, MS

West South Central if State = AR, LA, OK, TX

Mountain if State = MT, ID, WY, CO, NM, AZ, UT, NV

Pacific if State = WA, OR, CA, AK, HI

### **SIC 2**

The first two digits of the 6 digit SIC code.